

Insuser

From: Shaina Smith <shaina@uspainfoundation.org>
Sent: Wednesday, March 01, 2017 4:26 PM
To: Rep. de la Cruz, Joe; Sen. Fasano, Len; leonard.fasano@cga.ct.gov; Sen. Hartley, Joan; zRepresentative Rob Sampson; zRepresentative Eric Berthel; zRepresentative Tim Ackert; Rep. Albis, James; zRepresentative Tom Delnicki; zRepresentative Livvy Floren; Rep. Johnson, Susan; Rep. Lesser, Matthew; Rep. Paolillo, Alphonse; zRepresentative Cara Pavalock-Damato; Rep. Riley, Emmett; Bob.Siegrist@housegop.ct.gov; Rep. Steinberg, Jonathan; zRepresentative Kurt Vail; Christopher.Ziogas@cga.ct.gov; INSTestimony; Sen. Larson, Timothy; Sen. Kelly, Kevin; Rep. Scanlon, Sean; Shaina Smith
Subject: U.S. Pain Foundation Supports HB 7123; Please Consider as Testimony for Public Hearing

March 1, 2017

The Honorable Senator Timothy Larson
The Honorable Kevin Kelley
The Honorable Sean Scanlon

Co-Chairs, Senate Insurance and Real Estate Committee

Legislative Office Building, Room 2800
Hartford, CT 06106

Re: U.S. Pain Foundation Supports House Bill 7123

Dear Chairman Larson and members of the Insurance and Real Estate Committee,

U.S. Pain Foundation is the leading pain patient advocacy group in the nation, representing the interests of the 100 million Americans living with chronic pain. We seek to address the many challenges chronic pain patients face, ranging from social stigma to barriers to treatment. One major obstacle to care is the practice of non-medical switching. U.S. Pain is submitting this letter in support of House Bill 7123 as it would ensure Connecticut residents remain stable on their medically necessary treatment options, without interruption, for the duration of the health plan year. The organization also wishes to express its request for the committee to consider a bill amendment that would create grandfathering provisions; if a covered person who is stable on a medication renews his or her plan, then the insurer should honor the coverage from the previous year's plan.

Currently, Connecticut insurers are not required to honor the terms of the prescription coverage they advertise and sell to consumers. Taking advantage of this loophole, insurers frequently reduce coverage for medications midyear, forcing patients who are stable on a medication, even for years, onto an insurer-preferred medication. Because the coverage reductions happen after open enrollment, patients have no way to change plans and are locked into coverage that doesn't meet their needs.

Studies show that forced switches for non-medical reasons may lead to increased symptoms, side effects and even relapse of a patient's health condition. Research also demonstrates that these negative health consequences may actually increase overall utilization costs, as patients require additional medical care.

When a person living with a chronic pain or another chronic condition is subjected to non-medical switching practices, the outcomes can be devastating. For example, one study found that rheumatoid arthritis patients who were taken off of their medication experienced 42 percent more emergency room visits and 12 percent more outpatient visits.¹ In addition, because of the negative health effects, patients with rheumatoid arthritis, psoriasis, psoriatic arthritis, ankylosing spondylitis or Crohn's disease who were switched experienced 37 percent higher medical care costs and 26 percent higher total costs than patients who weren't switched.¹

With all this in mind, the tide is turning against permitting midyear formulary changes. Just this summer, a consumer workgroup of the National Association of Insurance Commissioners published a report recommending states prohibit major formulary changes.² It also should be noted that this report found that Medicare protects patients from non-medical switching. Negative formulary changes must be approved by the Centers for Medicare and Medicaid Services, and even if approved, affected enrollees are exempt from the change for the remainder of the year. In addition, Medicare patients must receive 60 days of advanced written notice of approved negative changes.² If Medicare can offer these protections, why can't commercial insurers?

Insurers are free to adjust their formularies during open enrollment, when consumers have a fair chance to review and compare their options. In addition, this bill would not prohibit generic substitution; non-medical switching involves patients being switched to an entirely new drug, not just a generic. Furthermore, health plans are still permitted to add new drugs to the formulary during the current plan year or remove drugs for safety reasons as dictated by the Food and Drug Administration.

U.S. Pain Foundation recommends a model act which is supported by several patient-centered organizations. Such a bill amendment to House Bill 7123 would ensure that patients and consumers who are stable on their prescription treatment medications by the prescribing provider would have continuous care. Third-party payers cannot make restrictive changes to the formularies after a plan year has begun or has been renewed, resulting in increased cost-sharing or loss of access to a medication.

On behalf of U.S. Pain Foundation and the one in three Americans living with chronic pain, and as a chronic pain patient myself, I respectfully ask that you **support** House Bill 7123 so that Connecticut ensures access to fair, reliable prescription insurance coverage.

The organization is happy to present model language that would further enhance House Bill 7123 and is grateful for the bill sponsors who presented legislation which protects chronic pain patients.

Respectfully,

Shaina Smith

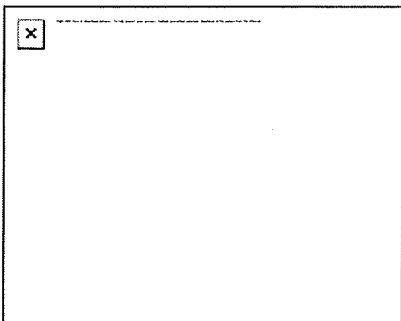
Shaina Smith
Director of State Advocacy & Alliance Development
U.S. Pain Foundation

Sources:

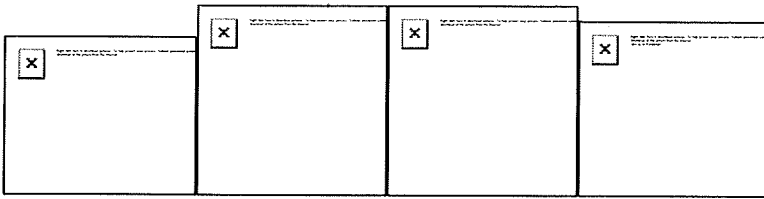
1. <http://www.uspainfoundation.org/wp-content/uploads/2016/01/costs-of-non-medical-switching-infographic.pdf>
2. <http://www.uspainfoundation.org/wp-content/uploads/2017/01/NAIC-Midyear-Formulary-Changes.pdf>

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Shaina Smith
Director of State Advocacy & Alliance Development
U.S. Pain Foundation Inc.



670 Newfield Street, Suite B
Middletown CT 06457
Home Office: 860.315.7307
Main office: 800.910.2462
Email: ambassadordirector@gmail.com



www.uspainfoundation.org

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